THE ATTORNEY GENERAL'S

1997 REPORT ON

HOSPITAL COMMUNITY BENEFITS

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Dear Friends and Colleagues:

I am pleased to issue the first summary report on the progress of Community Benefits in Massachusetts. It is the result of a careful review of 75 separate Community Benefits Reports filed with my office by every acute care hospital in the Commonwealth.

Those reports, as diverse as the institutions that provided them, are a tribute to the good faith cooperation of all concerned. Every acute care hospital has developed innovative community-based programs to address important health care needs of vulnerable and at-risk populations. These programs range from psychiatric counseling for senior citizens, medical clinics for the homeless, violence prevention seminars, to breast cancer screenings for the uninsured. The total amount budgeted or expended for such programs in fiscal 1995 was approximately $169.8 million. When reported amounts of unreimbursed free care are added, the total rises to more than $286.6 million.

We have now reached the third anniversary of the Community Benefits Guidelines initiative. I take this opportunity to reaffirm that the provision of community benefits is a high priority of my office, especially in light of the challenges hospitals face in this era of market-driven restructuring. As our report states, a shared focus on community benefits is, now more than ever, vitally important to the health, well being and social cohesion of all residents of the Commonwealth.

Thank you for your interest and participation.

Sincerely,

Scott Harshbarger

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THE ATTORNEY GENERAL'S 1997 REPORT ON HOSPITAL COMMUNITY BENEFITS

EXECUTIVE SUMMARY

In 1994, Attorney General Scott Harshbarger became the first Attorney General in the nation to issue voluntary Community Benefits Guidelines For Nonprofit Acute Care Hospitals. In a period of major downsizing among Massachusetts hospitals, this initiative energized and galvanized new and on-going efforts of Massachusetts hospitals to produce a strong commitment to community benefits and an impressive array of programs. The Guidelines set the standard in a new rough and tumble health care marketplace for a planned response to assessed health care needs.

Since the Guidelines were first issued, the Massachusetts health care landscape has changed dramatically. Academic health care centers and community hospitals alike are faced with a highly competitive marketplace where numerous providers are chasing a shrinking amount of health care dollars. Consolidations, federal cutbacks, the emergence of for-profit medicine in the Commonwealth, and the onslaught of managed care present major challenges to maintaining a health system where the health care needs of consumers and local communities come first. In the face of this changed environment, the Attorney General's Guidelines challenge hospitals to continue a focus on the health care needs of vulnerable and at-risk populations in communities across the Commonwealth. The Guidelines also challenge hospitals to give local communities a seat at the health care access table during this period of great change. The Guidelines are rooted in the concept that hospital commitment and caring for community fosters support and institutional loyalty in an era of market-driven restructuring.

Highlighted below are the Attorney General's findings from the hospitals' first full annual reports, covering fiscal year 1995. These reports were filed with the Attorney General's office through September 1996.

* All 75 acute care hospitals in Massachusetts provide community benefits and filed a Community Benefits report.

* Hospitals provided or budgeted a total of $169.8 million in community benefits and community service programs in Fiscal Year 1995, and when unreimbursed free care is included, the total is more than $286.6 million. Taken as a whole, these totals, at the time, represent between 2.4% and 4.0% of total patient health care expenses, signifying overall a commendable level of industry-wide community benefits.

* Hospitals reported an extensive variety of community-based programs, ranging from cancer and HIV screening, teen counseling, to violence prevention and substance abuse programs.

* The Attorney General's Report presents a classification of well-over 300 of these programs. While not a complete picture of the universe of community benefits programs, the compilation is useful as a rough snapshot of the types of programs generated in the community benefits process. The compilation at the end of this Report includes the following information:

    a) Over 20% of the selected programs are devoted to community education and health care screenings;

    b) Almost 10% of the programs are aimed at preventing domestic violence and elder and child abuse;

    c) 8% focus on drug and alcohol counseling and therapy;

    d) Almost 10% aim to provide more primary health care services to the uninsured and underinsured, and to remove language and cultural barriers to access;

    e) Over 16% of the selected programs provide funding for clinics, health centers and medical personnel sent to schools and health fairs.

  Additional information on this classification is found in Appendix D.

* Most hospitals have incorporated a commitment to community benefits into the hospital's organizational structure. Hospitals have adopted special Community Benefits Mission Statements and designated the Governing Board and senior management for oversight responsibility of planning and implementation.

* Hospitals report a record of community participation in the various stages of developing and implementing a community benefits plan that varies widely. One-third describe specific community mechanisms, such as community benefits advisory groups, that result in direct, extensive community involvement in community benefits planning. The other two-thirds, however, describe processes, in which community benefits decisions are made by the hospital board and staff without significant consultation with the community. While greater community participation may have occurred, it was not reflected in the reports.

* Most hospitals report a very commendable effort to extensively assess and measure the health care needs of their communities.

* Sixty of the 75 hospitals provided a list of health care priorities. As of the first 15 months under the Guidelines, over half of the hospitals reported a formal plan specifically designed to address these identified priorities.

* Hospitals' financial reporting was not uniform and varied from hospital to hospital. There were significant differences in terminology and detail, which made aggregation

difficult. Only 35 hospitals reports included a community benefits budget as recommended in the Guidelines.

In future reports, full financial reporting of community benefits budgets and expenditures is essential to allow the community and the public at large to understand hospitals' commitment to meeting community health needs. To this end, the Office of the Attorney General, in conjunction with the hospitals, is developing a uniform financial reporting template.

The hospital community benefits reports show that in an era of great marketplace turbulence many acute care hospitals continue to make substantial and significant contributions to improving community health in Massachusetts. As the health care industry continues to face significant challenges from managed care and for profit chains, the relationship between a hospital and community becomes all the more vital and important. Against this backdrop, it is more critical than ever that Massachusetts hospitals solidify and re-invigorate their commitments to the health care needs of their communities.

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In June 1994, the Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals were issued. Scott Harshbarger was the first Attorney General in the nation to ask hospitals, in partnership with their communities and in cooperation with other service providers, to make community benefits an integral part of their institutional missions. Community benefits programs with measurable goals, costs, and evaluation standards would be reported annually to the Office of the Attorney General.

The Guidelines state that, after each reporting cycle, the Attorney General would issue a record of hospital participation in the Community Benefits initiative. This summary Report reflects the status of the Massachusetts community benefits effort as reported for fiscal year 1995.

All acute care hospitals submitted an Interim Report and then an Annual Community Benefits Report, as requested in the Guidelines. These hospital community benefits submittals are publicly available for inspection in the Attorney General's Division of Public Charities.

An extensive array of innovative community-based programs are described in the 75 reports. Many hospitals also recorded the gross and net cost of those programs. Using FY 1995 hospital data, approximately $169.8 million was provided or budgeted for community benefits and community services in Massachusetts. When reported amounts of unreimbursed free care are added to the community benefits, the total rises to more than $286.6 million. It is anticipated that future hospital submittals will demonstrate further progress.

Background

While numerous factors led to the development of the Attorney General's voluntary Guidelines, one major concern was the lack of adequate medical coverage for 700,000 residents of the Commonwealth, 11.9 per cent of the population. In 1994 Massachusetts ranked twenty-second among the states in regard to the ratio of insured to total population. A census of those lacking medical coverage reveals the intractable nature of the problem: the uninsured in Massachusetts are disproportionately young adults, who work 40 or more hours per week, and who are members of racial and ethnic minority groups; they may be employed by small firms that do not provide coverage or may be unable to afford their share of a group health insurance premium.[1]

In order to assist both the uninsured and the underinsured, Attorney General Harshbarger, using the broad public protection powers of his office, enlisted the support of the Commonwealth's hospitals, from major academic hospital centers to small community hospitals. The Community Benefits Guidelines for Nonprofit Acute Care Hospitals were developed through lengthy consultation with industry and community representatives. Suggestions contained in more than 200 letters of comment were considered one by one and, where appropriate, were incorporated into the Guidelines.

The Attorney General's Guidelines took inspiration from the community benefit standards developed in 1989 by the Kellogg Foundation and in 1992 by the Catholic Health Association and the Voluntary Hospitals of America. Under these industry standards, each member hospital was encouraged to renew its charitable mission and enhance its social accountability.

Building upon these earlier standards, the Attorney General's Guidelines encourage community partnership and public reporting. To the well-honored Massachusetts tradition of hospital charity, the Attorney General's Guidelines add an inclusive participatory process to ensure that such charitable service corresponds to community health priorities.

In seeking a way to encourage hospitals to be as responsive to community needs as possible and to work in tandem with other service providers, Attorney General Harshbarger chose not to recommend the statutory models that had been developed by a number of other states.[2] The Attorney General's Office concluded that a non-regulatory approach was more appropriate for Massachusetts where charitable service was a shared obligation and where a legislative framework for the provision of hospital free care had been in place for many years.

Two further considerations led to the adoption of a non-regulatory approach. The greater flexibility of a voluntary program would allow each hospital to carry out a community benefits Plan adapted to its particular resources and expertise and the special needs of its target population. In addition, given the uncertainties of a legislative initiative, a voluntary approach could be developed and implemented with more predictability of outcome.

Within the broad framework of the voluntary Guidelines, no single definition of either "community" or "benefit" was prescribed. Instead, the Guidelines suggest that the choice be a local and evolving one, corresponding to changing public health needs. Although a hospital may choose a geographic, demographic, or disease-specific definition of community, or a mixture of those categories, and may provide clinical or non-clinical community health benefits, the Guidelines strongly recommend that every hospital give attention to the special needs of the poor, the elderly, racial, linguistic, and ethnic minorities, refugees and immigrants.

Recent Social and Economic Change

Since the Guidelines project first began in 1993, major social and economic changes have influenced health care delivery in Massachusetts, underscoring the need for accessible and appropriate community-based care. The period during which the Guidelines initiative took place may be viewed as a time of transition from the "Old Regime" of medical specialization

and costly fee-for-service to the "New Regime" of cost cutting managed care. In 1991, 27 percent of the Massachusetts population was enrolled in a health maintenance organization. By 1997, health maintenance organization enrollment had increased to 43 percent.[3] Consistent with the significant influence of managed care over health care consumers and the need to maintain a level playing field between hospitals and payors, the Attorney General issued Community Benefits Guidelines for Health Maintenance Organizations ("HMOs") in February 1996, covering both for-profit and non-profit HMOs.

Consolidation and Cost Pressures

The most dramatic change in Massachusetts health care delivery over the past three and a half years is the acceleration of mergers and for-profit acquisitions. From fiscal year 1990 to fiscal year 1996, at least fifteen hospital mergers took place.[4] The Guidelines now cover six new integrated health care systems that were not in existence when the project first began.

Further, since the deregulation of hospital rates during this same time, hospital budgets have been pressured by managed care organizations and other insurers to cut rates of hospitalization and to shorten length of stay. In an era of cost containment, with reduced public sector safety net funding, narrowed operating margins and intense competition for paying patients, there is a well-grounded fear that the plight of the uninsured and other vulnerable populations will fade from view.

The Changing Numbers of Uninsured

Unemployment rates have fallen during the years following the start of the Guidelines project, moving down from 6.9 percent in 1993 to 4.5 percent in 1996, but, as of the fall of 1997, this fortunate trend had not significantly improved the extent of insurance coverage.[5] More and more companies have curtailed health benefits as the cost of health care premiums have risen, requiring employees to increase their own financial contribution, especially for family members. More and more residents in Massachusetts are working part-time or for small employers, many of whom do not provide health coverage.

Recent studies indicate that the number of Massachusetts uninsured remained relatively stable in the four years following 1993, when the Guidelines project was first initiated.[6] It is now expected, however, that some portion of the 518,000 adults and 135,000 children currently uninsured in Massachusetts will be given medical coverage through one of the state's new health insurance initiatives.[7] But, as of the writing of this Report, it is too early to determine the full impact of the new programs.

For the reasons outlined above, the concerns that prompted the issuance of the 1994 Community Benefits Guidelines are still relevant today. The challenge to fulfill their charitable mission and respond to these concerns is all the greater for Massachusetts hospitals in the midst of a radical change in health care delivery.

Attorney General's Recent Health Care Initiatives

Attorney General Harshbarger, as president of the National Association of Attorneys General (NAAG) and founder of the NAAG Health Care Task Force, has made health care issues a top priority during his administration.

The Attorney General has spearheaded multi-state litigation against the tobacco industry to recoup millions of dollars in health care costs for the Medicaid budget and to establish new groundrules to protect the public health from tobacco-related disease. In addition, he has advocated for lower rates for Medicare supplemental insurance (Medigap and Medex). Further, to protect community interests, his office has scrutinized mergers and for-profit acquisitions of providers and HMOs.

Working closely with the legislative leadership and other advocates, Attorney General Harshbarger's office helped to secure the passage of two landmark pieces of state legislation: the Health Care Access Bill (Chapter 203 of the Acts of 1996) and the Act Increasing the Affordability and Accessibility of Health Insurance (Chapter 297 of the Acts of 1996). As a result of these legislative achievements in the Commonwealth, a Children's and Seniors' Health Care Assistance Fund will be established to provide expanded Medicaid access for children and prescription drug benefits for low income seniors. As noted above, federal monies have recently been approved to support this legislation.

Managed care report and recommendations

Most recently, Attorney General Harshbarger's office was the first Massachusetts state agency to issue a report on the state of managed care in Massachusetts. Based on the findings of this report, the Attorney General made a series of recommendations for a comprehensive regulatory framework, including the creation of a state Office of Managed Care to oversee HMOs and other managed care organizations.

The Attorney General has also convened a task force to enhance and improve quality and accountability in the growing home health care sector. Harshbarger is co-chair with Acting Governor Cellucci in a bi-partisan working group to improve private financing options for long-term care.

Participation in the Guidelines Initiative

There has been 100 percent hospital participation in the Guidelines initiative. Every acute care nonprofit hospital or hospital system in Massachusetts filed an Interim Report in February 1995 and, by September 1996, an Annual Community Benefits Report with the Attorney General's Division of Public Charities. This full compliance is a tribute to the spirit of cooperation in which the Massachusetts Hospital Association and hospitals across the state have participated in the drafting, training, and reporting process. The reports detail hundreds of community health and education programs which were operational during 1996 and, which, in many cases, continued into 1997.

The community benefits reports are collected in the Division of Public Charities and are available for public inspection during business hours. In order to give the hospitals' Annual Community Benefits Reports their widest possible audience, copies have been sent to the ten Massachusetts Prevention Centers throughout the state[8] as well as to the Western Massachusetts Office of the Attorney General.

THE 1996 ANNUAL REPORTS

Described below, principle by principle under the Guidelines, is the Massachusetts Community Benefits experience as reported by the 75 covered hospitals.[9]

A. The governing body of each hospital should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to a formal Community Benefits Plan.

The first Principle of the Guidelines requests that the Governing Body of the hospital affirm and make public its commitment to a partnership with the community and to the allocation of resources for accessible programs that address public health concerns. The Guidelines recommend that this commitment be made explicit in a special Mission Statement, reviewed and amended by the Governing Board as necessary. The special Community Benefits Mission Statement should be made public within the hospital's service area.

There was very broad compliance with this principle in that all but 7 of the 75 hospitals filing Annual Reports in 1996 provided a special Community Benefits Mission Statement. Of the statements provided, two-thirds express an explicit commitment to community collaboration or partnership. Thirty Mission Statements commit the hospital to an allocation of resources addressing broadly defined community health care needs.

B. The Governing Board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan, the method to be followed, the resources to be allocated, and the mechanism for its regular evaluation.

The second Guidelines principle calls on the Governing Board and senior management to take oversight responsibility for the implementation of the Community Benefits Plan. The Guidelines recommend that the hospital Board review the Plan periodically in order to make any necessary adjustments in resource commitment or direction.

The Annual Reports indicate that there was broad compliance with this principle. Twenty-three hospitals formed separate Board subcommittees to oversee the Community Benefits planning process. Fifty-three hospitals established in-house Community Benefits Advisory Groups, or similar structures, to take the lead in assessing public health needs and in organizing responsive programs.

The Guidelines stress the importance of integrating the Community Benefits planning body into the hospital's general policy and budgeting process. One-third of the Reports indicate that the Community Benefits advisory council is an integral part of the hospital organization.

C. A hospital should delineate a specific community or communities that will be the focus of its Community Benefits Plan and should involve representatives of that designated community in the planning and implementation process.

Delineating the Community

Practically all hospitals delineated a community benefits target area or population. Only six hospitals did not report that a specific community had been designated.

The Guidelines suggest three ways in which the target community might be defined: geographic, demographic or disease-specific. Most hospitals used the geographic boundary approach to delineate their target community and most selected all or part of their traditional service area. An aggregated map of the designated geographic communities would come close to covering the four corners of the Commonwealth.

About a third of the hospitals used a demographic approach to define the targeted community, often associated with a specific geographic area. A Boston hospital chose two geographic areas, Jamaica Plain and Mission Hill, and then one demographic group, low-income pregnant women and their families from Roxbury and Dorchester. Another hospital defined its community as children and adolescents living in poverty in three inner city areas.

Seven specialized hospitals used the disease-specific approach and directed their community benefits programs towards persons who had a particular health condition, such as AIDS or breast cancer.

Community Process and Input

The Attorney General's Guidelines emphasize the fundamental importance of a hospital-community partnership at every phase of the planning process: designating the beneficiary population; assessing unmet health care needs; choosing priorities; developing appropriate and responsive programs; allocating resources; determining short and long term goals; and evaluating progress in reaching them. The concept of partnership implies a mechanism of formal community participation which hospitals were asked to describe in their Reports. The Guidelines urge hospitals to develop such a mechanism and to include representatives of the racial, cultural, and ethnic community served.

One-third of the reporting hospitals appear to have clearly implemented the third Guidelines Principle calling for direct and extensive community involvement in the planning, development and evaluation of community benefits programs. Fourteen hospitals, and, in part, another nine, included members of racially and ethnically diverse local associations, representatives of the elderly, the frail and the disadvantaged in the heart of the decision-making structure.

The remaining two-thirds of the reports give a disappointing picture of the hospitals' community involvement efforts. Often, the reports indicate that community membership on the

community benefits planning committees involves only members of the hospital staff who also reside in the community.

According to the reports of at least twenty-five hospitals, the general opinions of the beneficiary population may have been periodically surveyed, and its perceptions duly noted, but community representatives are not full members of the hospital's Community Benefits planning mechanism. In other words, the community is informed, but not consulted, about the direction of the Community Benefits initiative. This is all the more surprising as the basic building blocks for a community consultation were readily available in the Department of Public Health's Community Health Network Area (CHNA) meetings in which numerous hospitals play a leadership role.

Thus, while a third of the Annual Reports indicate that a meaningful dialogue between acute care hospitals and their communities on the subject of community benefits has taken form, a stronger commitment to a full community benefits partnership appears to be needed for a majority of the acute care hospitals in the Commonwealth.

D. A Community Benefits Plan should include a comprehensive assessment of the health care needs of the identified community as well as a statement of priorities consistent with the hospital's resources.

The fourth Guidelines principle calls for a needs assessment and a determination of health care priorities. Particular attention to assessing the needs of the poor, of the elderly, of racial, linguistic and ethnic minorities, of refugees and immigrants is recommended. Hospitals are urged to develop bilingual survey instruments and employ interpreter services, where appropriate, in order to survey the community's own perceptions of unmet health care needs.

The Needs Assessment

The assessment of need was the aspect of the Guidelines process that was the most uniformly and effectively implemented. The reports indicate that, as recommended in the Guidelines, most hospitals involved medical staff, community leaders, and members of the beneficiary population in the determination of each area's most significant public health issues.

Sixty-six hospitals provided information on the public health status of their service area, using the CHNA data, the Preventable Hospitalization Rates from the Division of Health Care Finance and Policy, or information from other published data bases. Forty-three hospitals complemented this public health data with information from community perception surveys. Thirteen hospitals reported that their own medical staff was surveyed to determine whether experience in the field corroborated the formal needs assessment data or the community perceptions.

Establishing Priorities

Suggested criteria in the Guidelines for determining the health care priorities on which the hospital's Community Benefits Plan will focus include: the income level of the target population, barriers to access, absence of relevant resources, specific primary, acute or chronic health care needs, hospital capability, and available programs of other area agencies or providers.

There was broad compliance with this principle in that sixty of the hospitals provided a list of health care priorities drawn from the Needs Assessment data. However, this process of priority-setting appears to have been generally carried out by hospital trustees and staff alone. In approximately two-thirds of the Reports, there is no record of the involvement of community representatives in determining priority needs, developing a planned response, and setting short term and long term goals.

An Inventory of Programs

Once the most significant health problems have been identified using available data, community surveys, and hospital staff questionnaires, then the Guidelines recommend that existing programs addressing those public health problems should be inventoried. In establishing an inventory of existing programs, hospitals are urged to consider related programs developed by area human service agencies as well as programs funded by other health care providers. After this inventory has been established, the planning body should determine the need for any additional resource commitment.

Hospitals broadly implemented this principle in that fifty-nine reported that a community service and community benefits inventory had been made.

A Plan with Short and Long Term Goals

The Guidelines recommend that hospitals establish a Community Benefits Plan with short and long term goals based on quantifiable measures. Those goals might be an increase in the number of patients treated for a particular condition or a decrease in the number of residents afflicted with a particular disease.

Half of the reporting hospitals provided information on the specific goals of their Community Benefits Plans, goals such as a fifty percent reduction in the number of mothers not receiving adequate pre-natal care or a decrease in hospital admissions for asthma. Other hospitals may also have developed goals for their community benefits programs but did not articulate them in the annual report.

E. The hospital should implement its plan in a timely fashion.

Hospitals were asked to start the implementation of their Community Benefits Guidelines process as soon as possible. Suggested timelines were provided in the Guidelines, with a fifteen month beginning period for the Needs Assessment, the development of the Commu-

nity Benefits Plan, and the start of implementation. Further, hospitals were asked to indicate the time frame for implementing each aspect of the Plan.

It appears that significant steps such as the formation of the planning mechanism, the development and adoption of the Plan, were generally carried out by all reporting hospitals consistent with the timeframe suggested in the Guidelines. However, only twenty-two hospitals clearly articulated a time frame for implementing the Plan and no explanation for this omission was provided in the other reports.

F. Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its level of community benefits expenditures and describes the hospital's approach to establishing such expenditures.

In the development of the Guidelines, the sixth Principle, concerning the Annual Report and the Community Benefits Budget, was the object of great attention on the part of the hospital industry and the community health care advocates. There was sharp disagreement as to what should be reported, what financial measures should be used, and even whether there should be any budget disclosure.

The Level of Expenditure

The Attorney General's Office considered various approaches to the determination of an appropriate amount of community benefits expenditure. One possible approach was the identification of a "reasonable" expenditure level based on factors such as total unreimbursed free care, total patient related expenses and revenues, accumulated operating surpluses or deficits, and compensation levels in comparison to industry wide norms. A second possible approach involved specific target percentages that varied with the financial size of the institution.

The decision was made, at the time of the issuance of the Guidelines, to defer the question of target percentages until sufficient reporting data had been collected. The expectation was that hospitals would openly report the expenditure levels for their planned community benefits.

In the fiscal year 1995 submittals, however, there was a serious lack of uniform financial reporting and no general adherence to the financial reporting suggestions in the Guidelines. The reporting was very individualistic and varied from hospital to hospital.

Only thirty-five hospitals of the total seventy-five filed Reports which included a separate Community Benefits Budget. Of those, only sixteen indicated whether the amounts were gross or net. And even where hospitals reported having a Community Benefits budget, the total expenditure was not displayed against relevant financial measures. Information was not provided regarding the method used in quantification. In sum, financial data, if reported at all, was presented in a manner that was difficult to understand and appreciate.

The Community Benefits Budget

Mindful of the above limitations and caveats, we have calculated the total community benefits expenditures by Massachusetts acute care hospitals. Relying on the information provided in the fiscal year 1995 hospital reports, we estimate that the 75 covered hospitals provided or budgeted a total of $169.8 million in community benefits and community service programs. When unreimbursed free care is included, the total rises to more than $286.6 million.

Unfortunately, given the limitations of the financial information provided, it is not possible to ascertain whether the deferred target percentages were reached by each of the reporting hospitals. However, a rough comparison of aggregated expenditures against total patient health care expenses for the industry shows that, as a whole, acute care hospitals provided between 2.4 percent and 4.0 percent of patient-related expenses in community benefits. These percentages, although rough estimates, are consistent with the deferred recommendations on an industry-wide basis.

The Attorney General's office has been working to encourage hospitals to provide more complete information regarding Community Benefits budgets and expenditures as requested under the sixth Guidelines Principle. To ensure that future financial reporting is submitted in a manner that facilitates understanding by the community and the public at large, this office, in conjunction with the Massachusetts Hospital Association, will soon make available a community benefits financial template. Hospitals will be asked to use the template in filing their next community benefits report with the Office of the Attorney General.

COMMUNITY BENEFITS PROGRAMS

A chart appended to this Report as Appendix D, with a brief explanation of its terms, classifies selected community benefits and community service programs under several large headings. The programs selected and their classification are a matter of judgment and are offered as a approximate picture of the array and breakdown of community benefits programs.

We appreciate that there has been a time lag between reporting and dissemination of this information. Given the maturation of this process, we expect that there is more community benefits activity today than necessarily reported. The second Annual Reports, currently on file with the Division of Public Charities, describe additional programs that were planned or developed in fiscal year 1996 and that will further enrich the universe of community benefits.

Community Education and Screenings

The most frequently mentioned programs are Community Education and Screenings. Sixty-six separate programs, or 20.5% of the surveyed total, provide preventive health information and offer screenings to the community-at-large or to specific targeted groups.

For example, an urban Bristol County hospital provides health seminars for persons who use church soup kitchens. Another suburban Worcester county hospital offers a panoply of services for senior citizens: psychiatric treatment and counseling, health fairs, monthly screenings, free flu vaccines, and discounted meals, as well as assistance for family members. A Merrimack Valley area hospital has developed a program to ensure that elders have access to information on their health care options and answers to their insurance questions.

Suburban North Shore hospitals serving areas such as Lynn, Beverly, Ayer, and Stoneham have worked with area schools to develop appropriate educational materials about the dangers of smoking, poor nutrition, drunk driving, and unprotected sexual activity. One Fall River area hospital introduced a culturally sensitive educational program for Cancer Awareness at one local high school, whereas another school was provided with a new curriculum that focuses on cardiac health.

In an effort to strengthen at-risk families, a Springfield area hospital's GoodStart Program provides parenting skills workshops for new parents. A community hospital located in Middlesex County hospital has a Healthy Bodies/Healthy Babies Teen Pregnancy Support Program to enhance psychological and physical health in adolescent women through a variety of counseling and support programs. Support was provided free of charge to 50 pregnant teenagers.

Middlesex County community hospitals, serving areas such as Waltham, Marlborough, Melrose and Newton, have developed programs of breast and cervical cancer education which give free health services to uninsured women over age of 40. One specialized Boston hospital

has organized educational interventions designed to modify behaviors associated with risk of cancer, particularly for those with lowest access to preventive services such as the poor., the elderly, linguistic and cultural minorities, refugees and immigrants. That same hospital has worked with labor unions to deliver breast cancer education and smoking cessation counseling and has trained outreach workers to disseminate breast cancer information in poor and minority neighborhoods.

In order to improve community access to health care and information, one Hampshire County hospital has established a Community Health Information Center and a toll free resources information telephone line. A Framingham area medical center provides information on the importance of using car seats for children and ensures that every infant discharged from the hospital has a car seat at low cost rental or free of charge.

Medical Support of Licensed Health Care Providers

Within the compilation, the second largest program category was Medical Support of Licensed Health Care Providers. This category, which represents 53 programs or 16.5% of the total, includes direct funding for community based health centers and satellite clinics. Also included is the expense involved in sending hospital medical staff into a school or workplace to provide preventive health education or basic health care.

Community Development

The next most frequently reported type of community benefit program is that of Community Development. Forty-six programs, or 14.3% of the 322 surveyed, relate to the economic or social improvement of a specific area. One "Christmas in April" program in the Springfield area provides repairs and maintenance to area residents in need. Another Springfield area program encourages "reinvestment with local businesses." A Boston teaching hospital intends to fund a Chinatown Neighborhood Trust for community programs. A Fall River area hospital delivers donated groceries to at-risk house bound elders.

Urban and suburban hospitals, serving areas such as Brockton, Boston, and Ayer, have developed programs to educate job applicants, some participating in the MassJOBS Referral and Response Program by offering job skills training and voluntary employment for recipients of welfare. An urban western Massachusetts hospital system has worked closely with area schools to mentor at-risk students and to provide support for the transition from school to employment. The same hospital system has made low cost overnight housing available to families of ill children.

Disease Management

Thirty-three clinical community benefits programs, 10.2% of the surveyed total, relate to Disease Management. A Worcester county hospital has a focused asthma education and treatment program which includes a survey of physician practices to determine the appropriateness of care, a survey of HMO reimbursement rates for asthma patients and a survey of area pharmacies to determine the availability of peak flow meters. A community hospital in the

Winchester area has developed a special Diabetes Casefinding Program which aims to proactively identify and intervene with undiagnosed diabetics, those at-risk, and those who are diagnosed but not adequately treated.

A community hospital in the Malden area reports that it is working to build a continuum of breast health care from education to follow-up screenings, targeting adolescents, high risk women and elderly women, and will examine whether risk factors have been reduced. The program will finance screenings and, where needed, treatment for underinsured and uninsured women. A hospital in the Lowell/Lawrence area targeted the higher than average infant mortality rate in the Southeast Asian community and, through the coordinated efforts of several social service providers, reports that it was able to reduce that rate to slightly below state average.

Access to Care

Thirty-two programs (9.9 percent of the survey sample) aim to improve Access to Care. For example, one Worcester area medical center has organized an outreach program in a local housing project. An urban south shore hospital is holding bimonthly medical clinics for the homeless, and educating staff as to health issues that particularly affect that population. A Methuen/Haverhill area hospital is offering community based psychiatric services including an Hispanic Psychiatric Day Program.

A Boston teaching hospital has a Parent-to-Parent Project to improve access to health care for high risk pregnant women and infants. A rural hospital in Hampden county offers an Indigent Patient Drug Program for some 70 eligible patients in its service area who cannot afford to pay for medications.

Aiming to provide substance abuse treatment for those in need, a Cambridge area hospital has developed an innovative program to link agencies who treat substance abusers and those who help victims of domestic violence. It has also created outpatient treatment programs for substance abusers that are held during the day when the homeless are outside of shelters, and that are accessible to those without financial resources.

Numerous programs in urban areas such as Boston, Worcester, Brockton, reach underserved non-English speaking populations by increasing bilingual hospital staff, by disseminating public health information in several languages, and by holding classes in family health care in Spanish and Portuguese. One Boston teaching hospital, in order to provide culturally competent health care, is organizing special training and education for hospital staff, contractors, volunteers and Board. This includes an Asian Cultural Competency Project to sensitize staff to cultural beliefs related to medicine and healing.

Violence prevention

Thirty-two programs or 9.9 percent of the surveyed total were related to Violence prevention, the majority aiming to combat elder abuse.

One Springfield area hospital system is collaborating with a local police department in developing a community policing Domestic Violence initiative. Another, located in the Cape Anne area has a Partnership for Peace program with weekly meetings to develop conflict resolution and violence prevention techniques.

Two community hospitals in Boston area suburbs have joined forces to train Emergency Medical Service personnel to identify and assist victims of domestic violence. One Dorchester area hospital program developed with strong community collaboration is an off-hour, on-call volunteer network of women who were themselves victims of domestic violence and who mentor other battered women who have come to the hospital to seek emergency care.

One Boston hospital has developed a counseling, advocacy, and outreach project that targets young children who have witnessed violence. It is staffed by a multi-cultural, multi-lingual staff of social workers, psychiatrists, early childhood specialists and consulting child psychologists. A Boston teaching hospital, has a program that aims to identify victims early in the cycle of violence in order to link them to protection services. That program also trains health care workers to screen routinely for signs of domestic violence and to refer victims to advocates who offer individual counseling and assistance.

A community hospital in the Newton/Brookline area has developed an interdisciplinary domestic violence intervention protocol and a multi-agency education and counseling initiative that focuses on teen dating violence. The program also provides health and wellness services to battered women's shelters.[10]

CONCLUSION

The first Annual Community Benefits Reports describe a rich variety of programs that hospitals and communities are implementing to address community health needs. Although much remains to be accomplished, Massachusetts can be proud of this comprehensive effort to provide programs of affordable, accessible, and appropriate health care to those most in need.

The picture of the Massachusetts community benefits experience drawn from the first Annual Reports is positive in many respects. It is encouraging that almost every hospital has a Board-approved Community Benefits Mission Statement and that almost every hospital designated a specific beneficiary population and assessed that population's health status. Two-thirds of the reporting hospitals selected the underserved and vulnerable as the particular focus of their community benefits programs. Most hospitals affirmed the responsibility of the governing Board and senior management for overseeing the development and implementation of a focused Community Benefits Plan.

Notwithstanding this strong affirmation, important areas of concern are the apparent lack of community involvement in the Community Benefits decision-making process of many hospitals and the inadequate or imprecise financial reporting in so many Annual Reports.

While a substantial and significant contribution to community health care has been made by the reporting hospitals, there is still much to be done. We encourage those hospitals with strong community benefits programs developed in partnership with their communities to continue on this laudable course. As for hospitals whose reports indicate that more needs to be accomplished in order to make community benefits an integral part of their institutional missions, we urge them to redouble their commitment. The importance of partnership and collaboration to the health, well being and social cohesion of the citizenry of the Commonwealth has only increased over time.

ENDNOTES

[1] R. Blendon et al., Massachusetts Residents without Health Insurance, Harvard School of Public Health, 1995. Whereas 455,000 residents lacked health insurance in 1989, the number rose to 683,000 in 1995. See also, Uninsured in Massachusetts, B.U. School of Public Health, Summary findings, Nov.28, 1995.

[2] These first community benefits statutes were enacted by New York and Utah in 1990, followed by Texas (1993), Minnesota (1994), California (1994) and Indiana (1994). In early 1995, the Missouri Hospital Association and Missouri Department of Health developed a program called ACCESS which asks all health care providers to disclose their contribution to community health improvement, educational support and quality improvement.

[3] "HMO Enrollment Climbs to 36.5 Million Members in 1990," PR Newswire, April 26, 1991; Report of the Special Commission on Uncompensated Care, February 3, 1997, p.33.

[4] See list appended to Report as Appendix A.

[5] Average annual statistics provided by the Department of Employment and Training.

[6] Report of the Special Commission on Uncompensated Care, February 3, 1997, p.10. The Center for Budget Policy and Priorities estimated that one in three children in Massachusetts or about 354,000 children under age 18 went without health insurance for at least one month between 1994 and 1995, even though most were eligible for Medicaid.

[7] Chapter 203 of the Acts of 1996 provides for improved access to health care. Its stated purpose is "to immediately make available health care coverage to uninsured children and adults and to provide pharmaceutical benefits to the elderly." This bill was championed by the Attorney General and the Legislature which passed it over the Governor's veto.

[8] A list of the Massachusetts Prevention Centers, with their contact person and the specific hospital reports each Center has available, has been appended to this Report as Appendix B.

[9] A list of the hospital community benefits contact persons is provided as Appendix C.

[10] In addition to the categories of community benefits programs summarized above, the compilation includes programs that address Substance Abuse (8.07% or 26 programs), programs that are Support Groups (6.8% or 22 programs), and programs that involve improved Transportation (3.7% or 12).

APPENDIX A

HOSPITAL MERGERS

1990	Worcester Memorial/Worcester Hahnemann/Holden formed Medical Center of Central Mass. (now known as Memorial Health Care).
1990	North Shore Children's Hospital merged with Salem Hospital, operating as Salem Hospital.
1992	Framingham Union/Leonard Morse formed MetroWest Medical Center.
1992	St. John's/St. Joseph's formed Saints Memorial Medical Center.
1993	Burbank/Leominster formed Health Alliance.
1993	Cardinal Cushing/Goddard Memorial formed Samaritan Medical Center.
1995	Lahey Clinic/Hitchcock Clinic (Lebanon, NH) formed Lahey Hitchcock Clinic.
1995	Beverly/Addison Gilbert
1996	Cape Cod Health Systems and Falmouth Hospital Foundation formed Cape Cod Healthcare, Inc.
1996	St. Luke's, Charlton Memorial and Tobey health systems formed Southcoast Health Systems.
1996	Berkshire Health Systems/Berkshire Medical Center/Hillcrest Hospital
1996	Boston City Hospital, Boston University Medical Center Hospital.
1996	Cambridge Hospital Community Network/Somerville Hospital.
1996	Melrose-Wakefield, Whidden Memorial Hospitals formed Unicare Health System.
1996	Beth Israel Corp., Pathway Health Network, and Mount Auburn Foundation formed CareGroup: Beth Israel and Deaconess Hospitals formed Beth Israel Deaconess Medical Center.

Source: *Massachusetts Hospital Association*

APPENDIX A

ACQUISITIONS

1990	Hunt by Beverly Hospital
1990	St. Luke's of Middleborough by Cardinal Cushing General
1992	J.B. Thomas by Lahey Clinic
1993	Amesbury by Anna Jaques Hospital
1993	J.B. Thomas by Transitional Hospitals Corp., from Lahey Clinic
1993	St. Margaret's by St. Elizabeth's Medical Center of Boston
1994	Hahnemann by Vencor, Inc.
1994	Symmes, now Medical Center at Symmes by Lahey Clinic
1994	Winthrop by Boston University Medical Center Hospital and East Boston Neighborhood Health Center
1995	St. Joseph's Hospital of Saints Memorial Medical Center by Advantage Health Corp.
1996	Goddard Hospital of Good Samaritan Medical Center by Olympus Healthcare
1996	Advantage Health by Health South Corp.
1996	MetroWest Medical Center by Columbia/HCA
1996	Heritage Hospital by Somerville Hospital
1996	Saint Vincent Health Care System by OrNda HealthCorp

Source: Massachusetts Hospital Association

Healthy Communities Massachusetts Network
c/o AHEC/Community Partners
24 South Prospect Street
Amherst, MA 01002
413-253-4283
413-253-7131 FAX

Massachusetts Prevention Centers
Distribution of Non-profit Hospital Community Benefit Reports

WESTERN MASSACHUSETTS

Lower Pioneer Valley/Springfield area

Massachusetts Prevention Center
110 Maple Street, Suite 301
Springfield, MA 01104
413-732-2009, 800-789-3070
Amina Ali, Director

Baystate Medical Center
Sisters of Providence Health System
Springfield Municipal Hospital
Western Massachusetts Hospital

Hampshire, Franklin, & Berkshire Counties

Massachusetts Prevention Center
76 Pleasant Street
Northampton, MA 01060
413-584-3880, 800-850-3880
Jeff Harness, Director

Athol Memorial Hospital
Berkshire Medical Center
Charles River Hospital West
Cooley Dickinson Hospital
Fairview Hospital
Franklin Medical Center
Hillcrest Hospital
Holyoke Hospital
Mary Lane Hospital
Mercy Hospital and Providence Hospital
North Adams Regional Hospital
Rehabilitation Hospital and W. New England
VA Medical Center (Northampton)
Wing Memorial Hospital

CENTRAL MASSACHUSETTS

Greater Framingham/South Central

Massachusetts Prevention Center
158 Union Avenue
Framingham, MA 01701
508-875-5419
Susan P. Downey, Director

Harrington Memorial Hospital
Hubbard Regional Hospital
Marlborough Hospital
Metrowest Medical Center
Milford-Whitinsville Regional Hospital
Southwood Community Hospital

Greater Worcester/North Central

531 Main Street
Worcester, MA 01608
508-752-8083, 800-752-8083
Kirsten Nicholas, Director

Clinton Hospital Association
Deaconess-Nashoba Hospital
Fairlawn Rehabilitation Hospital
Fallon Healthcare System
Health Alliance Hospitals
Heywood Hospital
Medical Center of Central Massachusetts
Saint Vincent Hospital

NORTHEASTERN MASSACHUSETTS

Merrimack Valley/Lowell & Lawrence

Massachusetts Prevention Center
1 South Union Street
Lawrence, MA 01840
508-688-2323, 800*LIVEWELL
Zoraida Lebron, Director

Anna Jaques Hospital
Hale Hospital
Holy Family Hospital and Medical Center
Lawrence General Hospital
Lowell General Hospital
Saints Memorial Medical Center

West Suburban/North Shore

Massachusetts Prevention Center
27 Congress Street
Salem, MA 01970
508-745-8890, 800-334-5512
Carol Oliver, Director

Addison Gilbert Hospital
Atlanticare Medical Center
Beverly Hospital
Emerson Hospital
Lahey Clinic Hospital
Melrose-Wakefield Hospital
Northshore Medical Center/Salem Hospital

Massachusetts Prevention Centers
Distribution of Non-profit Hospital Community Benefit Reports
(Continued)

Salem Hospital
Shaugnessy Kaplan Rehabilitation Center
Winchester Hospital

GREATER BOSTON

City of Boston

Massachusetts Prevention Center
95 Berkeley Street
Boston, MA 02116
617-451-0049
Margaret Henderson, Director

Beth Israel Hospital
Boston Department of Health and Hospitals
Boston Regional Medical Center
Boston University Medical Center Hospital
Brigham and Women's Hospital
Caritas Hospital
Carney Hospital
Children's Hospital
Dana Farber Cancer Institute
Deaconess Hospital
Faulkner Hospital
Hebrew Rehabilitation Center for the Aged
Jewish Memorial Hospital and Rehabilitation Center
Massachusetts Eye and Ear Infirmary
Massachusetts General Hospital
Massachusetts Respiratory Hospital
Neponset Valley Health System
New England Baptist Hospital
New England Medical Center
New England Rehabilitation Hospital
New England Sinai Hospital
Partners Health Care System
Saint Elizabeth's Medical Center
Solomon Mental Health Center
Spaulding Rehabilitation Hospital
St. John of God Hospital
VA Medical Center (Boston)
Vencor Hospital

Boston Suburbs

Massachusetts Prevention Center
552 Massachusetts Avenue, Suite 203
Cambridge, MA 02139
617-441-0700
Marsha Lazar, Director

Brandeis University Health Services
Cambridge Hospital
Charles River Hospital
City of Waltham
Deaconess-Gloyer Hospital Corp
Deaconess-Waltham Hospital
Heritage Hospital
Lawrence Memorial Hospital of Medford
Malden Hospital
Medical Center at Symmes
Middlesex Hospital
Mount Auburn Hospital
Newton-Wellesley Hospital
Somerville Hospital
Whidden Memorial Hospital

SOUTHEASTERN MASSACHUSETTS

Brockton/Plymouth/South Shore

Massachusetts Prevention Center
942 West Chestnut Street
Brockton, MA 02401
508-583-2350
Randy Yates, Director

Braintree Hospital
Brockton Hospital
Brockton/West Roxbury VA Medical Center
Cranberry Specialty Hospital
Good Samaritan Medical Center
Jordan Hospital
Milton Hospital
Norwood Hospital
Quincy Hospital
South Shore Hospital
Sturdy Memorial Hospital

Fall River/New Bedford/Cape

Massachusetts Prevention Center
105 William Street
New Bedford, MA 02740
508-996-3147
Warren Berube, Director

Cape Cod Hospital
Charlton Memorial Hospital
Falmouth Hospital
Martha's Vineyard Hospital
Mediplex Rehabilitation Hospital
Morton Hospital and Medical Center
Nantucket Cottage Hospital
Southcoast Healthcare System
St. Anne's Hospital
St. Luke's Hospital
Taunton St. Hospital
Tobey Hospital

APPENDIX C

HOSPITAL COMMUNITY BENEFITS CONTACT LIST

Anna Jaques Hospital
Susan Gustafson
Director of Community Benefits

Athol Memorial Hospital
Allen Young
Director, Community Relations

AtlantiCare Medical Center
Frederick M. Cole
Director of Community Relations

Baystate Health Systems
Todd Lever
Regulatory Affairs Specialist

Beth Israel Hospital
Ediss Gandelman
Director of Community Benefits

Berkshire Medical Center
Sharon Semanie
Director, Community Relations

Boston Regional Medical Center
Christine Hawrylak
Public Relations & Development Director

Boston University Medical Center Hospital
Valerie Daniels
Director of Community Relations

Brockton Hospital
Dr. Carol Bortman
Director of Community Benefits

Cape Cod Hospital
Barry Carrus
Director of Community Affairs

Carney Hospital
Joyce Davis Coleman
Director, Community Benefits

Charlton Memorial Hospital
(See Southcoast Hospitals Group)

Children's Medical Center
Deborah C. Jackson
V.P. for Network Development & Community Services

Clinton Hospital
Kathy Fadden
Director of Community Relations

Columbia MetroWest Medical Center
Peter J. Martin
Chair, Community Benefits Task Force

Cooley Dickinson Hospital, Inc.
Marilyn Richards
Director, Behavioral Health Services

Dana-Farber Cancer Institute
Anne Levine
Director of Planning

Deaconess Hospital
Ann Ormond
Director, Community Relations and Marketing

Deaconess Glover Hospital
Lawrence Townley
Director, Community Relations

Deaconess - Nashoba Hospital
Carolyn Barney
V.P. of Public Relations & Community Benefits

Deaconess-Waltham Hospital
Ann M. Ormond
Director, Community Relations and Marketing

Emerson Hospital
Leslie Luppold
Senior Vice President, Operations

Fairview Hospital
Lauren Smith
Dir., Community Relations & Development

Falmouth Hospital
A. Kathy Regis
Community Outreach

Faulkner Hospital
Tracy Martel
Community Benefits Coordinator

Good Samaritan Medical Center
Charlene Pontbriand
V.P. for Public Advocacy & Philanthropy

Harrington Memorial Hospital
Richard M. Mangion
President & CEO

HealthAlliance
John Cross
Community Relations & Marketing

Heywood Hospital
Lorie Martiska
V.P. of Community Relations

Hillcrest Hospital
Delphine Boss
Director of Community Relations

Holy Family Hospital & Medical Center
Mary Ellen Davis
Administrative Assistant

Holyoke Hospital
David Wilbur
Director of Planning

Hubbard Regional Hospital
Cynthia A. Stearns
Director, Public Relations

Jordan Hospital, Inc.
Christina Nordstrom
Community Health Education Director

Lahey Hitchcock Clinic
Kathleen Hartig
Community Benefits Coordinator

Lawrence General Hospital
Barbara Keller
Public Relations Coordinator

Lawrence Memorial Hospital of Medford
Donna Newcomb
V.P., Development, Marketing
and Community Relations

Lowell General Hospital
Lisa Breen
Director, Planning & Marketing

Malden Hospital
Pamela Frankudakis
Community Relations Manager

Marlborough Hospital
Mary Anne Robbins
Director of Marketing

Martha's Vineyard Hospital, Inc.
Deborah Jernegan
Community Benefits & Special Projects Mgr.

Mass. Eye and Ear Infirmary
Mary Elaine Leach
Director of Public Affairs

Medical Center of Central Mass.
Robert J. Ristino, Chair
Community Benefits Standards Committee

Melrose-Wakefield Hospital
Debra Shapiro
Director, Community Services Development

Milford-Whitinsville Hospital
Jennifer Ansart
Community Benefits Coordinator

Milton Hospital
Richard Brooks
Vice President of Corporate Services

Morton Hospital & Medical Center
Dori Bingham
Director of Public Affairs

Mount Auburn Hospital
Debra Taylor
Director of Planning

Nantucket Cottage Hospital
Michael Sullivan
Director of Community Relations and Dev.

Neponset Valley Health System
Diana M. Franchitto
Director, Network Development & Mktg.

New England Baptist Hospital
Janice Sullivan
Director of Community Relations

New England Medical Center
Howard Spivak
V.P. of Business and Community Health Programs

Newton-Wellesley Hospital
Ron Ponte
Director, Community Partnerships

Noble Hospital
Marjorie Flaherty, RN
Vice President of Nursing

North Shore Medical Center/Salem Hospital
Matt Fishman
Director of Community Benefits Programs

North Adams Regional Hospital
Dianne M. Cutillo
Director of Marketing, Public Relations and Development

Northeast Health Systems
(Addison Gilbert and Beverly Hospitals)
John L. Good, III
Vice President, Community Affairs

Partners HealthCare System, Inc.
Matt Fishman
Director of Community Benefits Programs

Pathway Health Network
Priscilla Cohen
Vice President, External Relations

Saints Memorial Medical Center
Valerie Tramack
Administration

Sisters of Providence Health System
Wendy Taylor
Director of Community Relations

Somerville Hospital
Linda Cundiff
Director of Community Relations

South Shore Hospital
Richard Pozniak
Senior Communications Associate

Southcoast Hospitals Group
Joan E. Roover
Vice President, Corporate Programs

St. Anne's Hospital
Julie Ramos Gagliardi
Community Benefits

St. Elizabeth's Medical Center
Linda Phelan
Manager of Community Benefits

St. Luke's Hospital
(See Southcoast)

St. Vincent Hospital
Paula Green
Director of Public & Community Relations

Sturdy Memorial Hospital
Linda MacCracken
Director of Planning and Marketing

Tobey Hospital
(See Southcoast)

University of Mass. Medical Center
Karen Scholz
Director Health Policy Research

Whidden Memorial Hospital
Janet Schweitzer
Director, Community Relations

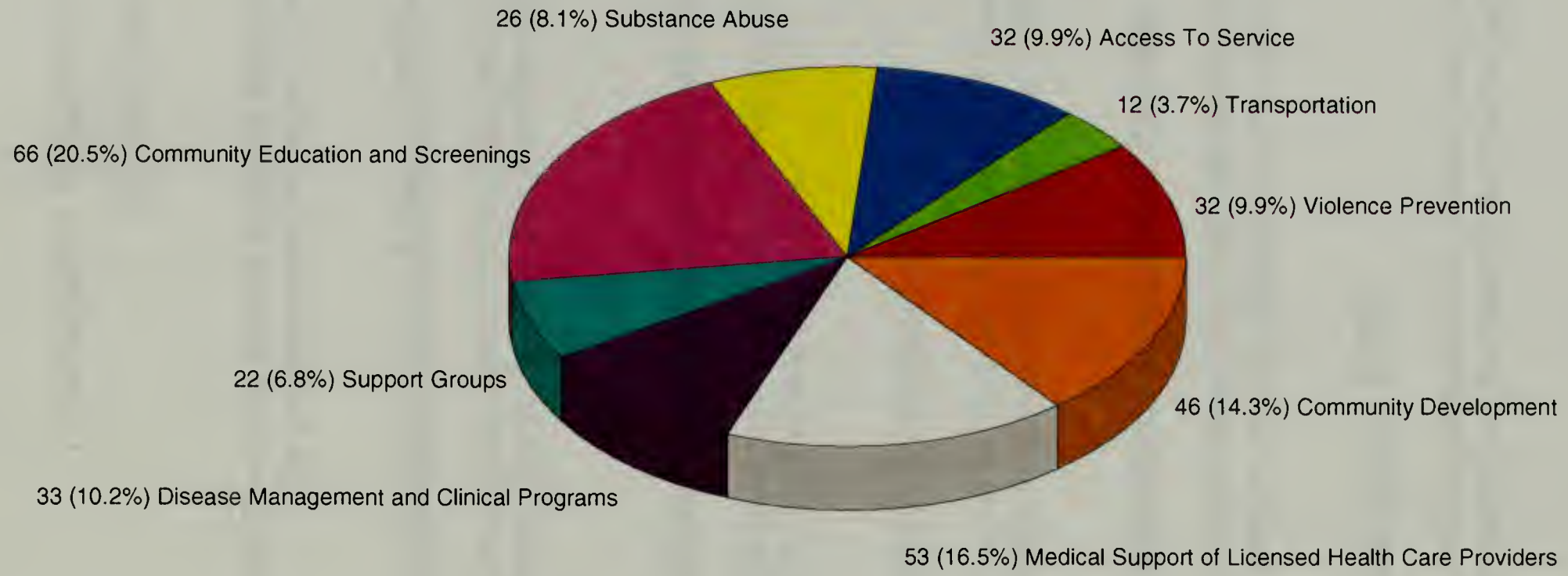
Winchester Hospital
Kathleen Beyerman
Director, Community Health Institute

Wing Health System, Inc.
Judith Duval
Director of Marketing & Development

Attorney General's Office
Community Benefits Program

This chart reflects 322 of the programs reported by 75 hospitals.

Community Benefits Program Breakdown
As Reported



APPENDIX D

COMMUNITY BENEFITS PROGRAMS DEFINITIONS

322 reported community benefits programs were entered into a computerized database. The programs were divided into the following categories:

Community Education and Screening (20.5%)

Programs that screen for cancer, HIV, prostate cancer, high blood levels of lead. Programs that provide information on nutrition, dangers of smoking, and how to prevent asthma crises, and so forth.

Medical Support of Licensed Health Care Providers (16.5%)

These programs provide funding for satellite clinics, community health centers, and medical personnel sent to schools and health fairs.

Community Development (14.3%)

These programs aim to improve employment and housing in order to strengthen the community's ability to sustain itself. Included are programs that address environmental issues.

Disease Management and Clinical Programs (10.2%)

Programs that provide free or low-cost treatment and follow-up for persons who have cardiac or pulmonary disease, arthritis, diabetes, cancer, and so forth.

Access to Service (9.9%)

This category includes programs that provide more primary care health services to the uninsured or underinsured and that seek to remove language and cultural barriers to that health care.

Violence Prevention (9.9%)

Programs that aim to prevent domestic, elder and child abuse were grouped under this heading.

Substance Abuse (8.1%)

Programs that provide counseling and behavior modification therapy to drug and alcohol abusers.

Support Groups (6.8%)

Support groups that are organized for victims of Alzheimers disease, prostate cancer, diabetes, obesity, and so forth.

Transportation (3.7%)

Includes programs that fund vans and other forms of transportation, free or at low cost, to and from the hospital for patients who are unable to afford private means.